No. 97-2000

Supreme Court, U.S.
FILED
JUL 13 1998
CLERK

IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY, *et al.*,
Petitioners,

v.

DOROTHY SCOTT SULLIVAN, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF OF *AMICI CURIAE* AMERICAN INSURANCE ASSOCIATION, ALLIANCE OF AMERICAN INSURERS, NATIONAL ASSOCIATION OF INDEPENDENT INSURERS, INSURANCE FEDERATION OF PENNSYLVANIA, STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, NATIONAL ASSOCIATION OF MANUFACTURERS, NATIONAL COUNCIL OF SELF-INSURERS, UWC-STRATEGIC SERVICES ON UNEMPLOYMENT COMPENSATION & WORKERS' COMPENSATION, PENNSYLVANIA MANUFACTURERS' ASSOCIATION, PENNSYLVANIA SELF-INSURERS' ASSOCIATION, PENNSYLVANIA DEFENSE INSTITUTE AND PENNSYLVANIA RETAILERS' ASSOCIATION IN SUPPORT OF THE PETITION

MARK F. HORNING
Counsel of Record
SHANNEN W. COFFIN
STEPTOE & JOHNSON LLP
1330 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 429-8126
Counsel for *Amici Curiae*

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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BRIEF OF *AMICI CURIAE* AMERICAN INSURANCE ASSOCIATION, *ET AL.*, IN SUPPORT OF THE PETITION

INTEREST OF THE *AMICI*

Amici curiae respectfully submit this brief in support of the petition for writ of certiorari to the Third Circuit.[1] *Amici curiae* American Insurance Association, Alliance of American Insurers and National Association of Inde-

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[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no counsel for any party to this dispute authored this brief in whole or in part and no person or entity, other than *amici curiae* and their member companies, made a monetary contribution to the preparation or submission of this brief. Most of the private insurer petitioners are members of one of the *amici* insurance industry trade associations.

pendent Insurers are national insurance industry trade associations and Insurance Federation of Pennsylvania is a state insurance trade association whose member companies write a substantial portion of the workers' compensation insurance policies in Pennsylvania, the state in which this case arose. *Amicus curiae* State Farm Mutual Automobile Insurance Company is an insurance company that writes automobile and homeowners' insurance in Pennsylvania and throughout the country. *Amici curiae* National Association of Manufacturers, National Council of Self-Insurers, UWC-Strategic Services on Unemployment Compensation & Workers' Compensation, Pennsylvania Manufacturers' Association, Pennsylvania Self-Insurers' Association, Pennsylvania Defense Institute, and Pennsylvania Retailers' Association are all trade or advocacy organizations that, among other things, represent the interests of employers.

Amici have a substantial interest in supporting the petition for certiorari for two reasons. *First*, the appellate court's decision subjects insurers and self-insured employers to liability as state actors for administering claims arising under their private contracts of workers' compensation insurance or self-insurance plans. The holding below thus would require insurers and self-insurers to adopt burdensome adjudicative-type procedures for resolution of claims disputes not required by their agreements or state regulatory law.

Second, the Third Circuit ruling strikes down an important legislative reform of the workers' compensation system in Pennsylvaia and threatens to undo similar reforms in other states. The costs of the medical care component of workers' compensation benefits experienced geometric growth in the 1980's and early 1990's. In response, many states enacted legislation to contain the costs of medical care, including enhanced employer and insurer authority over the delivery of medical treatment. One dimension of this authority was stronger "utilization review" measures to determine the reasonableness and

necessity of medical treatment for injured employees. The lower court's decision would seriously impair these reforms by rendering utilization review ineffective as a means of combating fraud and unnecessary treatment by medical care providers.

Due to *amici*'s familiarity with the workers' compensation system of the various states and the role of private insurers and self-insured employers in it, this brief addresses the potentially significant implications of the Third Circuit's decision for insurers and employers.[2]

SUMMARY OF ARGUMENT

State Action Issue: The Third Circuit's state action holding should be reviewed because it would broadly extend the requirements of the Due Process Clause to private insurers and self-insured employers, thereby creating a new federal system of constitutional insurance regulation in conflict with state regulation. Such a federal scheme is especially problematic in light of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, in which Congress established a federal "hands-off" policy in insurance regulation.

The lower court viewed private workers' compensation insurers as performing a traditionally governmental function because they acted as an "arm" or "partner" of the state in administering a system of "public benefits." Pet. App. at 14a-15a. In fact, however, the benefits paid by an insurer under workers' compensation insurance policies do not fulfill any financial obligations of the state itself but rather the private contractual obligation of an insurer voluntarily electing to write coverage for the employer's risk of liability. In no sense, therefore, do workers' compensation insurers provide a service that traditionally has been the prerogative of the state. The lower court regarded claims payments under these policies as "public benefits" solely because insurers are extensively regulated and because the workers' compensation law is the "exclu-

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[2] All parties have consented to the filing of this brief, and letters of consent have been filed with the Office of the Clerk of this Court.

sive" remedy for insured workers. Under this rationale, virtually all of the claims-handling practices of private insurers would be transformed into state action regardless of whether the state actually mandated or actively encouraged the practice.

Moreover, because many states also extensively regulate other insurance markets and limit tort remedies (*e.g.*, under "no fault" automobile insurance laws), the decision below could force many other types of insurers to adopt quasi-adjudicative procedures for claims disputes that would impose significant new costs and potentially reduce the availability of private insurance.

Alternatively, the Third Circuit held that private insurers were state actors because they made informational filings with state regulators that were subject to ministerial review for completeness but not on the merits. However, many privately-initiated insurer practices must be described in filings with state regulators, in particular, rates and policy terms. Under the Third Circuit's decision, this private conduct would be transformed into state action irrespective of whether state regulators mandated the practice or affirmatively approved it after substantive review. The Third Circuit's alternative holding should thus be reviewed because it threatens to transform regulated insurers into state actors merely because of a regulator's acceptance of or acquiescence in a filing.

Due Process Issue: The Third Circuit's separate due process holding should be reviewed because it threatens to nullify numerous state reforms, over the past decade, seeking to contain the costs of medical care and thus to enhance the availability and affordability of insurance coverage. The Pennsylvania utilization review statute struck down in this case was designed to prevent overtreatment and fraud by medical care providers by allowing insurers and self-insured employers to obtain medical peer review of provider bills to determine whether treatment previously given to injured workers was reasonable and necessary. The appellate court's decision erroneously

assumed that an insurer's mere delay in paying a disputed bill, pending completion of utilization review, was tantamount to a cutoff of medical benefits to the injured worker—even though, in the cases affected by the statutory provisions in dispute, that worker already had received the disputed treatment. Based on this misconception, the appellate court required insurers to pay for the disputed treatment before the outcome of utilization review—at which point, any excessive payment previouly made to the provider cannot, for legal and practical reasons, ever be recovered. The lower court's decision should thus be reviewed because it calls into question the constitutional validity and effectiveness of numerous state utilization review statutes applicable not only to workers' compensation insurance but also to automobile, health and disability policies affording medical benefits.

ARGUMENT

I. THIS COURT SHOULD REVIEW THE THIRD CIRCUIT'S EXPANSIVE RULING THAT PRIVATE WORKERS' COMPENSATION INSURERS ARE "STATE ACTORS"

A. The Third Circuit Erroneously Concluded That Private Workers' Compensation Insurers Are "Arms" of the State

The Third Circuit considered workers' compensation insurers to be state actors for essentially two reasons. First, the court concluded that, "[a]lthough the insurance companies are private entities, when they act under the construct of the Workers' Compensation system, they are providing public benefits which honor State entitlements. In effect, they become an arm of the State, fulfilling a uniquely governmental obligation . . . ." Pet. App. at 14a-15a. Second, the lower court found that an insurer's mere notice to the Pennsylvania Bureau of Workers' Compensation ("Bureau") that it was initiating utilization review and the Bureau's review of the form for completeness amounted to active state encouragement of the insurer's unilateral decision to suspend payment of health care pro-

vider bills pending such review. *Id.* at 15a. These holdings reflect a fundamental misunderstanding of the workers' compensation system and the role of private insurers in it.

In Pennsylvania, as in other jurisdictions, the obligation to pay workers' compensation benefits falls upon employers. *See* 77 Pa. Stat. Ann. § 431. Thus, workers' compensation benefits are not a publicly-funded entitlement program like Social Security disability, Medicare or Medicaid.

Moreover, the coverage written by workers' compensation insurers is much the same as other types of third-party liability coverage that protects a policyholder, in this case the employer, against a potential legal liability, in this case liability for payment of lost wages and medical treatment caused by work-related accidents. Claims payments under workers' compensation policies are therefore no more of a "public benefit" than claims paid by insurers to other third parties as a result of legal liability (*e.g.*, claims paid to persons injured by an insured's negligence).

Nor does the workers' compensation law conscript insurers to administer benefits payments on behalf of the state and thus make the insurer a "partner or an arm of the State" in implementing the workers' compensation law. Pet. App. at 15a. Property casualty insurers are not required to write workers' compensation coverage; they unilaterally and voluntarily decide whether to write such coverage and can withdraw from the market at any time. Indeed, in the legislative debate which preceded passage of the 1993 reforms at issue in this case, one Pennsylvania House member argued that cost containment measures were necessary because "insurance companies, an awful lot of them in Pennsylvania, are refusing to write workers' compensation . . . [because] they cannot make a profit . . . ." Floor Statement of Rep. Fargo, Pa. House Journal at 547 (Mar. 30, 1993).

Nor is the state a joint decisionmaker with the insurer. The insurer alone makes decisions on underwriting and

implementing the terms of its contracts, including the investigation and payment of claims. The workers' compensation insurer thus performs the same private, commercial functions as other types of insurers.

Insurers' only relationship with the state is that they are subject to regulation. For example, they must be licensed to write workers' compensation insurance, the coverage afforded under a policy must include all benefits directed by statute, and the rates are approved by the Insurance Commissioner. *See* 77 Pa. Stat. Ann. § 997 (power of Commissioner to revoke workers' compensation insurance license); 77 Pa. Stat. Ann. §§ 1035.1 *et seq.* (workers' compensation insurance rating law). In these respects, workers' compensation insurance is no different from many other types of regulated policies, such as automobile insurance.

The Third Circuit's decision also reflects a basic misunderstanding of the state's involvement in the insurer's decision to invoke utilization review of provider bills and to suspend payment until the completion of review. The determination of eligibility for and payment of benefits is made by the insurance company itself as a matter of contract. When the worker is injured, the insurer must first make a determination whether the injury was occupationally related. It then reviews and pays the provider's medical bills.

The Commonwealth has only two types of involvement in this claims payment process. First, it regulates the type of benefits to be paid and the amount paid. For example, the 1993 legislation challenged here established a schedule of fees for various types of medical treatment. *See* 77 Pa. Stat. Ann. § 531(3). Second, the state creates various dispute resolution procedures—including utilization review—for disputes among employees, employers, insurers and medical care providers over entitlement to or amount of payment. Those procedures are designed to foster the private and informal resolution of these disputes.

The private insurer itself unilaterally determines whether to seek utilization review. The Commonwealth does not

initiate utilization review, mandate it or screen those cases best suited for such review. The insurer merely files a form with the Bureau notifying it of the insurer's decision to seek utilization review of disputed treatment. *See* Pet. App. at 5a. The Bureau then conducts a limited, non-substantive review to ensure that the form is properly completed. "The Bureau's review of the Initial Request does not address the legitimacy or lack thereof of the request for utilization review." *Id.*

Nor does the state lend any active encouragement to the insurer's decision to withhold payment of the provider bill pending utilization review. The insurer has the option, but is not required, to suspend payment to a provider immediately upon requesting utilization review with the Bureau. *See* Pa. Code § 127.208(e).

Once the insurer requests review, the utilization review panel is randomly selected from a roster of medical providers in the same profession or specialty as the provider whose treatment is under review. Pet. App. at 6a-7a. The providers are all private parties and not employees of the Commonwealth. No state official is involved in the utilization review process as a panelist, investigator or adjudicator, and panel members deal directly with the provider and the insurer. The state first becomes actively involved if the insurer, employer, employee or provider appeal the utilization review panel's decision to an administrative law judge. *See* 77 Pa. Stat. Ann. § 531(6)(iv); 34 Pa. Code § 127.208(f).

The utilization review procedure can thus be likened to a dispute where first mediation and then actual litigation ensue. The insurer first attempts to mediate the dispute with the provider by using private mediators, namely, the utilization review panelists. If the utilization review fails to resolve the dispute, the parties may litigate in an administrative law forum. It is only then that the Commonwealth becomes involved in the resolution of the dispute but does so only as an impartial factfinder. Prior to that stage, the decisions at issue—whether to dispute the

reasonableness and necessity of medical treatment and to suspend payment—are made solely by the private insurer.

The decision below should be reviewed because it significantly expands the "public function," "symbiotic relationship" and "active state encouragement" tests for determining whether the conduct of regulated private businesses can be attributed to the state. The payment of workers' compensation benefits under private contracts of insurance cannot be viewed as a governmental function. The test is whether the private enterprise is exercising "powers traditionally exclusively reserved to the State." *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 352 (1974). Here, private insurers are not providing benefits that the state has an obligation to provide. *See Dillard v. Industrial Comm'n of Va.*, 416 U.S. 783, 798 (1974) (noting that funds used to pay workers' compensation benefits "are private, not public").

Nor does a private insurer become a "partner" of the state (*see* Pet. App. at 15a) and thus have a "symbiotic relationship" merely because it is subject to state regulation—even "extensive and detailed" regulation. *Jackson*, 419 U.S. at 350. Finally, Pennsylvania's mere acquiescence in the insurer's decision to seek utilization review and to delay payment in the meantime cannot constitute "active state assistance." As noted in *Blum v. Yaretsky*, 457 U.S. 991 (1982), "[m]ere approval of or acquiescence in the initiatives of a private party is not sufficient to justify holding the State responsible for those initiatives. . . ." *Id.* at 1004-05 (citations omitted); *see also Life Ins. Co. v. Reichardt*, 591 F.2d 499, 502 (9th Cir. 1979) (alleged discriminatory terms of disability insurance policy not product of state action despite the fact that form was approved by Commissioner of Insurance because "state does not command the discrimination," but merely performs "pro forma" review).

B. The Third Circuit's State Action Decision Has Broad Implications for a Variety of Insurance Coverages

Precisely because the lower court's state action decision was based primarily on the regulated status of workers' compensation carriers, its ruling has potentially broad implications for other workers' compensation insurance practices and other regulated insurance markets.

By broadly characterizing private workers' compensation insurers as an "arm" of the state in administering a program of "public benefits," the decision below has ramifications going far beyond utilization review. Insurers potentially could be treated as state actors in connection with *any* activity associated with the payment of benefits to injured workers. This might include, for example, the underwriting of policies that affects the ultimate availability of benefits; determinations whether injuries are occupationally related and thus eligible for benefits; and decisions affecting eligibility for disability (as opposed to medical) benefits (*e.g.*, termination of temporary total disability benefits upon a worker's recovery). In all of these instances, the insurer could be treated as a state actor, under the Third Circuit's rationale, without receiving any active assistance from a state official. Moreover, application of the lower court's state action rationale threatens to subject insurers to constitutional constraints under other provisions of the Constitution as well. For instance, insurers could be required to guarantee equal protection to their policyholders and beneficiaries. The decision below thus threatens to create an entirely new system of federal constitutional requirements and remedies for insurance policy disputes on top of the contractual and administrative remedies created under state law. This result would be antithetical to the policy of federal deference to state insurance regulation. *See* McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15.

The group most immediately affected by the Third Circuit's ruling, other than workers' compensation insurers,

are self-insuring employers. Self-insured employers perform most of the same functions as insurers and are subject to much of the same regulation. The appellate court's decision thus would treat *all* types of private businesses, in their capacity as employers, as state actors, not just insurers.

The Third Circuit's state action rationale might also extend to other regulated insurance markets. This is because, in concluding that workers' compensation insurers are state actors, the lower court relied heavily upon three characteristics of Pennsylvania's workers' compensation scheme which are common to many types of insurance coverage.

First, the court relied on the fact that the workers' compensation system is an "exclusive remedy": "an employee cannot opt-out of Pennsylvania Workers' Compensation scheme." Pet. App. at 14a. Second, the court noted that Pennsylvania imposes "a statutory obligation upon the employer to pay for all work-related injuries of his/her employees," which must be satisfied either by insurance or self-insurance. *Id.* at 14a n.18. Third, the court emphasized that the "Commonwealth has enacted a complex and interwoven regulatory web enlisting the Bureau, the employers, and the insurance companies." *Id.* at 14a. These three characteristics—the substitution of a statutory remedy for common law remedies, a mandate to purchase insurance, and extensive regulation—are common to many types of insurance.

There are, for example, numerous state and federal law mandates that private parties purchase insurance coverage. For example, all fifty states and the District of Columbia require automobile drivers to post financial security in order to operate a motor vehicle, usually by mandating the purchase of automobile liability insurance.[3] Many states

[3] Ala. Code § 32-7-6; Alaska Stat. §§ 28.22.011, 28.22.101; Ariz. Rev. Stat. §§ 28-4009, 28-4135; Ark. Code Ann. §§ 27-22-103, 27-22-104; Cal. Veh. Code §§ 16020-16021; Col. Rev. Stat. § 10-4-705;

require companies engaged in the business of remediating pollution from underground storage tanks to provide evidence of financial responsibility, which may be in the form of insurance or self-insurance. *See, e.g.*, 35 Pa. Stat. Ann. § 6021.701; N.J. Stat. Ann. §§ 58:10A-24.3, 58:10A-24.4(b). In federal law, the Price-Anderson Act requires that licensed nuclear facility operators obtain the maximum amount of liability insurance available from private sources. 42 U.S.C. § 2210(b). The Miller Act requires federal government contractors to post surety bonds for the performance of their construction contracts. *See* 40 U.S.C. §§ 270a-270d.

Similarly, many states have substituted an "exclusive" statutory remedy for tort liability.[4] The best examples

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Conn. Gen. Stat. § 38a-371; Del. Code Ann. tit. 29, §§ 2902, 2948; D.C. Code Ann. §§ 35-2103, 35-2106; Fla. Stat. Ann. §§ 627.733, 627.736; Ga. Code Ann. § 33-4-5; Haw. Rev. Stat. §§ 431:10C-104, 431:10C-301; Idaho Code §§ 49-1209, 49-1212; 625 Ill. Comp. Stat. 5/7-601; Ind. Code Ann. §§ 9-25-4-1 through 9-25-4-5; Iowa Code § 321A.5; Kan. Stat. Ann. § 40-3104; Ky. Stat. Ann. § 304.39-080; La. Rev. Stat. Ann. § 32:861; Me. Rev. Stat. Ann. tit. 29, § 1601; Md. Transp. Code Ann. §§ 17-103, 17-104; Mass. Ann. Laws ch. 90, §§ 34A-34B; Mich. Stat. Ann. § 24.13101; Minn. Stat. § 65B.48; Miss. Code Ann. § 63-15-11; Mo. Rev. Stat. § 303.025; Mont. Code Ann. § 61-6-301; Neb. Rev. Stat. Ann. § 60-508; Nev. Rev. Stat. Ann. § 485.185; N.H. Rev. Stat. Ann. § 264:3; N.J. Stat. Ann. § 39:6A-3; N.M. Stat. Ann. § 66-5-205; N.Y. Veh. & Traf. Law § 312; N.C. Gen. Stat. § 20-279.5; N.D. Cent. Code § 39-08-20; Ohio Rev. Code Ann. §§ 4509.19, 4509.20; Okla. Stat. tit. 7, § 601; Or. Rev. Stat. § 806.010; 75 Pa. Cons. Stat. § 1305; R.I. Gen. Laws § 31-31-6; S.C. Code Ann. § 56-9-450; S.D. Codified Laws § 32-35-113; Tenn. Code Ann. § 55-12-105, 55-12-106; Tex. Transp. Code Ann. § 601.051; Utah Code Ann. § 41-12a-301; Vt. Stat. Ann. tit. 23, § 800; Va. Code Ann. §§ 46.2-435, 46.2-436; Wash. Rev. Code §§ 46.29.060, 46.29.080; W. Va. Code § 17D-2A-3; Wis. Stat. §§ 344.14, 344.15; Wyo. Stat. Ann. § 31-9-202.

[4] At the federal level, at least one federal district court has applied reasoning similar to the Third Circuit in this case to conclude that self-insured employers paying federal workers' compensation benefits under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §§ 901-950 ("LHWCA"), are state actors. *See Kreschollek v. Southern Stevedoring Co.*, Civ. No. 93-3903,

are automobile liability laws which, like workers' compensation laws, substitute a "no fault" compensation standard for previously-available tort remedies.[5] And, of course, most lines of property/casualty insurance—including automobile, homeowners' and commercial property and liability—are subject to an extensive administrative system of regulation governing rates, underwriting, policy terms and claims payments.

The Third Circuit's expansive state action test threatens to convert private insurers into state actors in each of these situations. Under the lower court's rationale, the mere fact that the policyholder is required to buy insurance or that its statutory remedies are exclusive would make the regulated insurer an "arm" of the state in administering an "exclusive" system of "public benefits." Private insurance contracts would become a state entitlement requiring the insurer to treat claimants as if they were beneficiaries of public funds.

In particular, the Third Circuit's finding of state action based on an insurer's filing with a state regulator has potentially broad ramifications. As regulated companies, insurers frequently are called upon to make informational, notice and other filings with state regulators. They must, for example, file rates and policy forms. *See, e.g.*, 77 Pa. Stat. Ann. § 1035.5 (Pennsylvania workers' compensation insurers "shall file with the commissioner

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Order at 5-7 (D. N.J. Sept. 30, 1997). The LHWCA subjects employers to mandatory workers' compensation liability and directs them to secure payment of benefits for injured employers, which they may do by purchasing insurance. 33 U.S.C. §§ 904, 932. LHWCA benefits are a covered employee's exclusive remedy against an employer. *Id.* § 905.

[5] *See, e.g.*, Col. Rev. Stat. §§ 10-4-701 *et seq.*; Conn. Gen. Stat. §§ 38a-363 *et seq.*; Fla. Stat. Ann. §§ 627.730-627.7405; Haw. Rev. Stat. §§ 431:10C-101 *et seq.*; Ky. Rev. Stat. Ann. §§ 304.39-010 *et seq.*; Mass. Ann. Laws ch. 90, § 34M; Mich. Stat. Ann. §§ 24.13101 *et seq.*; Minn. Stat. §§ 65B.41 *et seq.*; N.J. Stat. Ann. § 39:6A-4; N.Y. Ins. Law. §§ 5101 *et seq.*; N.D. Cent. Code §§ 26.1-41-01 *et seq.*; Utah Code Ann. §§ 31A-22-301 *et seq.*

all rates and supplementary rate information"). This Court, however, has never regarded the state's acquiescence in such filings—even where subject to state review—as converting a private party's conduct into state action.

For example, in *Blum*, the Court held that a private nursing home's decision to transfer Medicaid patients could not be attributed to the state despite the fact that "the State requires the nursing homes to complete patient care assessment forms and file them with state Medicaid officials . . . [and] federal law requires that state officials review these assessments." 457 U.S. at 1010 (citations omitted). Similarly, under the analogous "state action" doctrine of the antitrust laws, the conduct of regulated businesses has never been attributed to the state merely because a regulator approves a tariff or similar filing. *See, e.g., Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976). Yet, under the Third Circuit's test, a regulated company's mere filing with a state regulatory agency and its ministerial, non-substantive review would convert the privately-initiated conduct into state action. The decision below should thus be reviewed because it has the potential for broadly governmentalizing the conduct of private businesses in regulated markets.

II. THE THIRD CIRCUIT'S DUE PROCESS DETERMINATION ALSO MERITS REVIEW

A. The Third Circuit's Ruling Threatens to Eviscerate State Utilization Review and Similar Medical Care Cost Containment Measures

The Third Circuit's due process ruling should also be reviewed because of its significant implications for the cost containment reforms enacted by many states to deal with the workers' compensation financial crisis of the past decade.

Beginning in the mid-1980's, workers' compensation markets in Pennsylvania and many other states entered a long period of turmoil due to exploding costs and insur-

ance rates that did not keep up with the costs. One of the principal causes of this crisis was steeply accelerating medical care costs. From 1985 to 1992, aggregate national medical expenditures for workers' compensation rose from $7.08 billion to $18.25 billion, for an increase of over 157%, compared to a 94% rise in national health care costs overall. S. ECCLESTON & C. YEAGER, WORKERS COMPENSATION RESEARCH INSTITUTE, MANAGED CARE AND MEDICAL COST CONTAINMENT IN WORKERS' COMPENSATION, A NATIONAL INVENTORY, 1997-1998, at 4 (1997).

Overtreatment and fraud, particularly by non-traditional providers such as chiropractors and acupuncturists, was a principal source of the problem. In Pennsylvania, the pre-1993 system created several incentives for providers to overtreat and overbill.

First, the worker, not the employer or insurer paying the bill, had the right to choose the provider following the first fourteen days after an injury. *See* R. VICTOR, J. GARDNER, D. SWEENEY & C. TELLES, WORKERS COMPENSATION RESEARCH INSTITUTE, COST DRIVERS IN SIX STATES, at 94 (1992). Second, "[e]mployers or insurers [were] required to pay disputed medical bills pending resolution of a dispute, with little chance of reimbursement." *Id.* at 94. Third, "[e]ven if a medical bill [was] challenged successfully, reimbursement [came] from a special state fund, not from the provider who submitted the bill. Consequently, providers [had] no incentive to avoid overbilling." *Id.* These problems were compounded because "Pennsylvania employ[ed] few of the cost containment strategies common to other states . . . ." D. BALLANTYNE & C. TELLES, WORKERS COMPENSATION RESEARCH INSTITUTE, WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY, at xxi (1991).

To address the workers' compensation crisis, in 1993 the Pennsylvania Legislature enacted omnibus reforms, including a provision permitting insurers and self-insured

employers to withhold payment of health care provider bills pending utilization review of the reasonableness or necessity of the treatment. *See* 77 Pa. Stat. Ann. § 531(5); 34 Pa. Code §127.208. In permitting insurers to forebear payment, the Pennsylvania legislation brought the Commonwealth in conformity with the practices in virtually all other states. ECCLESTON & YEAGER, *supra*, at 16, 18-19.

The 1993 reforms in general and the utilization review system in particular have proved remarkably effective. "The most notable system improvement was a sharp drop in medical benefit costs from 1993 to 1995," attributable in large part to the "medical cost controls instituted by the 1993 amendments." D. BALLANTYNE, WORKERS COMPENSATION RESEARCH INSTITUTE, REVISITING WORKERS' COMPENSATION IN PENNSYLVANIA: ADMINISTRATIVE INVENTORY, at xi (1997). From the inception of utilization review until early 1998, there were 41,583 cases decided by utilization review panels. Letter from Timothy Wisecarver, President, Pennsylvania Compensation Rating Bureau, to Mr. Richard Himler, Director, Pennsylvania Bureau of Workers' Compensation (July 1, 1998) (reproduced in the Appendix to this brief). In 43% of those cases, the treatment was found to be unreasonable or unnecessary; in another 24%, the treatment was found to be partly unreasonable or unnecessary. *Id.* Thus, in over two-thirds of all cases, treatment was found to be improper and excessive payments were avoided.

The lower court's decision, however, will render utilization review meaningless as a mechanism to protect against payment for unreasonable and unnecessary treatment. The court struck down that part of the Pennsylvania statute that allowed payments to be delayed beyond thirty days of billing if the insurer requests utilization review. 77 Pa. Stat. Ann. § 531(5). But the utilization review panel, in practice, takes between sixty and ninety days to reach its conclusion. Should it then determine that the treatment

was unnecessary and unreasonable, its decision will have no practical effect. The insurer already will have paid the provider, and the provider is insulated from returning that payment because the insurer is legally barred from recovery. *See Moats v. Workmen's Compensation Appeal Bd.*, 588 A.2d 116, 118 (Pa. Commw. Ct. 1991).

The Third Circuit's ruling will thereby open the door to provider fraud and abuse. Providers will have every incentive to bill for improper treatment because they know they will be able to receive payment but will not be forced to disgorge it even if the treatment is later found unnecessary. The Third Circuit's ruling thus does more than merely impose onerous procedural requirements on utilization review—it frustrates the very purpose of the Pennsylvania reform.

In turn, because the insurer cannot recover fraudulently induced or otherwise excessive payments, the costs of coverage are likely to increase significantly. An illustration of this phenomenon is found in the wake of the three-judge panel's decision in *Baksalary v. Smith*, 579 F. Supp. 218 (E.D. Pa. 1984), *appeal dismissed*, 469 U.S. 1146 (1985). In *Baksalary*, the panel invalidated provisions of a prior Pennsylvania workers' compensation statute that, like the provision in issue here, permitted an employer or insurer unilaterally to suspend disability benefits prior to resolution of a dispute over the worker's continuing eligibility. As in the case of medical benefits, insurers were prohibited from recovering excessive payments from the employee even though subsequently found to be ineligible. Instead, insurers could recover only from a special "supersedeas" fund financed by assessments on them—in essence, requiring the industry to bear the entire cost of the excessive benefits.

In the year that *Baksalary* was decided, reimbursements from the supersedeas fund were fairly minimal, amounting to $1.6 million. *See* BALLANTYNE & TELLES, *supra*, at 37. Since that decision, however, the reimbursements from the fund have skyrocketed to over $25.2 million in

1995, a growth of nearly 1500%. BALLANTYNE, *supra*, at 72. Because the fund reimbursements are "socialized" among insurers and self-insured employers through annual assessments, however, the effect of the *Baksalary* decision has been to greatly increase the insurer's costs of providing coverage.

Insurers are similarly limited to the supersedeas fund in recovering excessive payments to medical care providers. 34 Pa. Code § 127.208(g). The Third Circuit's *Sullivan* ruling thus threatens to greatly increase supersedeas fund assessments on insurers, resulting either in reduced availability of insurance, if the costs must be absorbed by the insurer, or higher rates, if the costs are passed on to employers.

The Third Circuit's ruling also could have significant implications for other lines of insurance, in particular, automobile, disability and health insurance. Many states permit utilization or similar review procedures for medical or disability benefits under these types of policies. Under the Third Circuit's "payment first, review second" approach, the constitutionality of all of these widespread procedures are drawn into question.

B. The Third Circuit's Decision Will Not Protect the Interests of the Injured Employee

The Third Circuit's due process ruling erroneously equated a mere delay in paying the provider's bill with a decision to terminate the employee's medical care benefits. This assumption reflects a basic misunderstanding of the type of utilization review at issue.

The utilization review affecting the plaintiffs in this case was *retrospective* only, that is, a review of a bill for treatment previously given. A delay in paying a bill thus could not affect the availability of treatment *already provided*.

Nor, as a practical matter, does the mere delay in paying for past treatment cause the provider to withhold future treatment. Under Pennsylvania law, if the provider

prevails during the utilization review process, he is entitled to full retroactive relief plus ten percent interest and attorney's fees. 77 Pa. Stat. Ann. §§ 717.1(a), 996(a). The provider also has ethical and legal obligations to continue to provide needed medical care. Not surprisingly, then, several commentators have concluded that retrospective utilization review has little to no effect on an injured employee's access to health care.[6] In short, while purporting to protect the constitutionally-protected interests of the injured worker, the Third Circuit actually is protecting only the provider's interest in getting paid irrespective of the reasonableness of the treatment provided.

Moreover, the Third Circuit's requirement that injured workers be allowed to make written submissions to the utilization review panel giving their subjective or layman's view of treatment is unlikely to improve the accuracy of the panel's determinations. Such decisions, like disability benefits eligibility determinations in cases such as *Mathews v. Eldridge*, 424 U.S. 319 (1976), are made on the basis of objective medical reports. What is "necessary" and "reasonable" medical treatment is determined by established medical protocols and actual medical evaluations. *See* 34 Pa. Code § 127.467 (reviewers must apply "generally accepted treatment protocols" in conducting utilization review). The utilization review panel already has ac-

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[6] *See* A. Fehn, *Comment: Are We Protected from HMO Negligence?: An Examination of Ohio Law, ERISA Preemption, and Legislative Initiatives*, 30 AKRON L. REV. 501, 506 (Summer 1997) ("While these 'retrospective' utilization reviews would sometimes result in an insurer's refusal to pay the health care provider, the review never affected the patient's access to health care.") (footnote omitted); R. Conrad, Jr. & P. Seiter, *Health Plan Liability in the Age of Managed Care*, DEFENSE COUNS. J., April 1995, at 191 (under retrospective utilization review, "[i]ssues of medical necessity and cost effectiveness may be argued between providers and carriers, but the patient's access to care is not directly affected"); P. Mihaly, *Health Care Utilization Review: Potential Exposures to Negligence Liability*, 52 OH. ST. L. J. 1289, 1289 (1991) ("[W]hile a retrospective payment denial may lead to heated disputes over who will pay the doctor or hospital, it usually does not have a significant impact on the patient's care.").

cess to all medical reports relating to the employee and is able to discuss them directly with the provider. *See* 34 Pa. Code § 127.469.

The lower court's misunderstanding of utilization review points to the basic reason why its due process decision should be reviewed. Under the guise of constitutional analysis, the appellate court really made discretionary policy judgments about the proper balance between the employee's interests in obtaining needed medical treatment and the insurer's and employer's interests in preventing fraud and unnecessary treatment. The record demonstrates that the court's judgments were based on serious misconceptions about the workers' compensation system and utilization review. That is why these kinds of judgments should be left in the hands of state legislators and regulators, who are best-equipped to make such judgments.

CONCLUSION

For the reasons stated above, this Court should grant the petition for review of the Third Circuit's decision.

Respectfully submitted,

MARK F. HORNING
Counsel of Record
SHANNEN W. COFFIN
STEPTOE & JOHNSON LLP
1330 Connecticut Avenue, N.W.
Washington, D.C. 20036
(202) 429-8126
Counsel for *Amici Curiae*

APPENDIX

APPENDIX [1]

[PCRB Logo]

Pennsylvania Compensation Rating Bureau
The Widener Building • 6th Floor
One South Penn Square • Philadelphia, PA 19107-3577
(215) 568-2371 • FAX (215) 564-4328

July 1, 1998

VIA FACSIMILE & FIRST CLASS MAIL

Mr. Richard Himler
Director
Bureau of Workers' Compensation
Department of Labor & Industry
Commonwealth of Pennsylvania
1171 South Cameron Street, Room 103
Harrisburg, PA 17104-2501

RE: Utilization Review Experience under Pennsylvania's Workers Compensation Act

Dear Mr. Himler:

Thank you for your office's prompt and cooperative action in providing the Pennsylvania Compensation Rating Bureau (PCRB) with an electronic data file reflecting all utilization review requests filed from the inception of the utilization review processes in Pennsylvaia through the early part of 1998. That information is of great interest and utility to us and will serve as a primary basis for our analysis and review of that process in the context of the recent Sullivan case decision.

The Sullivan case decision would invalidate parts of the utilization review process as previously applied in Pennsylvania, including the invocation of an automatic super-

[1] A copy of this letter was lodged with the Office of the Clerk of the Supreme Court on the date of filing of this brief.

sedeas during the pendency of utilization review requests. To the extent that utilization review requests take longer to decide than the time in which employers or insurers are required to pay medical bills once presented, the loss of the automatic supersedeas provision would require payments which would not be recovered from providers even if the ultimate utilization review decision were to find the treatments not to be reasonable or necessary.

Meaningful evaluation of these possibilities will require additional information, some of which is not currently available, including the ultimate disposition of the Sullivan case through the judicial process and what modifications, if any, are imposed on the workers compensation system at large and the utilization review process in particular in response to that decision. However, I want to take this opportunity to briefly describe what we now know and additional efforts under way to increase our understanding of the utilization review process and the potential ramifications of the Sullivan case thereon.

Using the data file which your office provided, the PCRB has tabulated results of utilization review requests on which at least an initial decision had been rendered. I enclose a copy of that tabulation, which focused on the three most significant "decision indicator" codes contained in the data file as described below:

Decision Indicator: The decision indicator field contains several alphabetic entries, the most common of which are "Y," "N" and "P." A "Y" decision found that the contested medical service(s) *was/were* reasonable and necessary. An "N" decision found that the contested medical service(s) was/were *not* reasonable or necessary. A "P" decision found that the contested medical service(s) was/were reasonable and necessary in *part* and was/were not reasonable or necessary in other *part*. These codes were entered by Bureau of Workers' Compensation staff both for initial decisions and for reconsideration requests processed in Pennsylvania.

In the columnar entries on the left side of the enclosed page we have shown the number of utilization review requests filed, the number of initial decisions rendered by type and numbers of reconsideration decisions rendered by type for each kind of previous initial decision. Thus, the data file contains 48,695 utilization review cases, of which 41,583 had had an initial decision recorded as of the date of production of the Bureau of Workers' Compensation data file. (The remaining 7,112 requests had not yet been decided as of the date of production of the data file we are using.) Some 8,646 cases also had reconsideration decisions recorded as of the date of this data file's production.

We have tracked the combined effects of initial decisions and reconsideration decisions in the matrix shown on the right side of the enclosed page. This matrix shows that "N" decisions were most common, representing somewhat more than 43 percent of all decisions. "Y" decisions were rendered in just over 31 percent of all cases, and "P" decisions resulted in approximately 24 percent of cases.

Since our production of the enclosed tabulation, I have also come to understand that a Decision Indicator "O" began to be used in late 1995. This code indicates a decision that treatment was not reasonable or necessary and that the provider under review did not supply records as requested. While much less common than any other Decision Indicator even after 1995, if added to our tabulation these decisions would serve to increase somewhat the portion of decisions finding that treatment under review was not reasonable or necessary.

The enclosed tabulation clearly demonstrates that the utilization review process as historically applied in Pennsylvania has affected a majority of cases to which the process was applied by finding part or all of disputed treatments not to be reasonable or necessary. At present, the PCRB does not have available information which would quantify the dollar amounts of those effects. However,

we are presently in the process of seeking additional information from many independent sources concerning the dollar values of medical services at issue in utilization review cases, as well as implications of utilization review decisions on ongoing indemnity benefits. As any additional information is obtained in that process, we will continue to keep your office informed.

Sincerely,

/s/ Timothy L. Wisecarver
TIMOTHY L. WISECARVER
President

TLW/kg
Enclosure

Utilization Data Claim Counts

		Reconsideration Results Where Available						
Total Number of claims	48,695							
Total Number with Initial Decision Rendered Date	41,583	**"Y"**	**"N"**	**"P"**	**"Other"**		**Net Count**	
Number with "Y" Initial Decision Indicator	12,100	667	363	295	2	**"Y"**	**13,022**	**31.32%**
Number with "N" Initial Decision Indicator	19,034	1042	3,132	1068	10	**"N"**	**18,016**	**43.33%**
Number with "P" Initial Decision Indicator	9,718	539	737	777	1	**"P"**	**9,807**	**23.58%**
Number with other than above Indicator	731	1	2	3	7	**"Other"**	**738**	**1.77%**
Total Number with Reconsideration Decision Rendered Date	8,646						**41,583**	**100.00%**
Number with "Y" Initial Decision Indicator	1,327							
Number with "Y" Reconsideration Indicator	667							
Number with "N" Reconsideration Indicator	363							
Number with "P" reconsideration Indicator	295							
Number with other than above Indicator	2							
Number with "N" Initial Decision Indicator	5,252							
Number with "Y" Reconsideration Indicator	1,042							
Number with "N" Reconsideration Indicator	3,132							
Number with "P" reconsideration Indicator	1,068							
Number with other than above Indicator	10							
Number with "P" Initial decision Indicator	2,054							
Number with "Y" Reconsideration Indicator	539							
Number with "N" Reconsideration Indicator	737							
Number with "P" reconsideration Indicator	777							
Number with other than above Indicator	1							
Number with other than Y, N, P Init. Dec. Ind.	13							
Number with "Y" Reconsideration Indicator	1							
Number with "N" Reconsideration Indicator	3							
Number with "P" reconsideration Indicator	2							
Number with other than above Indicator	7							